‘Home First for Intermediate care’

Summary Report

Lancashire and South Cumbria

July 2019

Executive Summary (1/3)

- The intermediate care system in Lancashire and South Cumbria has been a cause for concern for system leaders for some time. There have been both quality and performance issues in parts of the system, and a lack of clarity around what integrated care is seeking to deliver. In recognition of this, CF were commissioned by the Lancashire Better Care Fund Steering Group to:
  - Understand the current usage of intermediate care across Lancashire and South Cumbria
  - Model future demand if there are no changes to the model of intermediate care
  - Develop a new model of care working with local clinicians and professionals
  - Model the impact of changes to the model of intermediate care
  - Understand considerations for implementation
- The Lancashire and South Cumbria health and care system today is characterised by higher than average levels of 'superstranded' patients in acute hospital beds (those staying more than 21 days), and a higher rate of delayed transfers of care. There is also significant variation in the pattern of use across Lancashire and South Cumbria, reflecting the differences in offer and approach in different areas. Unsurprisingly, given that the focus of care is on support to avoid admission to acute care, or rehabilitation and reablement after an an acute episode, the majority of service users are over 75 and frail, with many having dementia or a cognitive impairment.
- Today, the Lancashire and South Cumbria system spends an estimated £43m/year on around 45,000 episodes of care across a range of bed and home based health and care services.
- There is no consistent model of intermediate care across Lancashire, and the system is complex, fragmented and difficult to navigate for both staff and service users.
- There is also significant variation in outcomes, with users in parts of Lancashire and South Cumbria 150% more likely to need admission to a social care bed within 30 days of an intermediate care episode, than in other parts of the system.

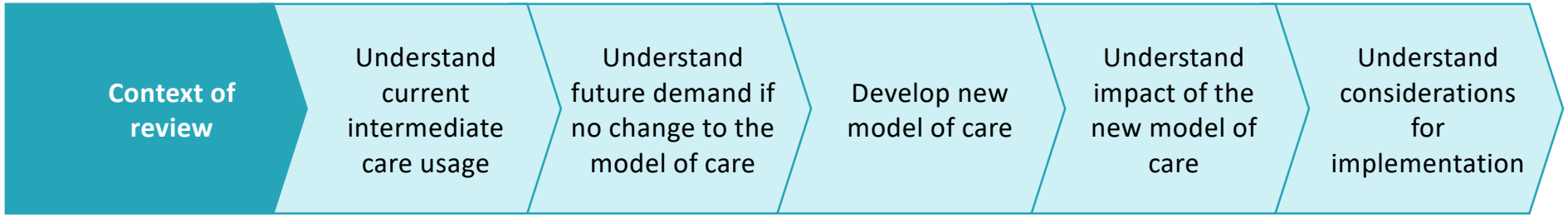
Executive Summary (2/3)

- We modelled the potential future demand for intermediate care based on demographic change, assuming there was no change in the care model. By 2029, there will be many more elderly people in Lancashire and South Cumbria - 8% more aged between 65 and 74, 33% more aged between 75 and 84 and 35% more over 85.
- While demographic changes would increase the demand for care episodes by 26% in Lancashire and South Cumbria, cost inflation and the increased shift towards more costly episodes of bed based care would increase the overall cost by 67%, delivering this would cost an additional £27.5m in ten years time, assuming no change to the model of care. Additional demand in the acute and social care sectors that could be managed by intermediate care adds a further £51m and £6.3m, respectively, to system cost.
- We facilitated a clinical and professional group to develop a new care model through a series of workshops. The group reviewed their current models and best practice examples from elsewhere, and agreed a set of design principles. These were focussed on keeping care at home, maximising independence and providing timely integrated health and care with smooth transitions between care settings to support both step up and step down.
- The group recognised that delivering against these design principles required breaking down the traditional barriers between services and developed a model of care based on only three services. This would require leaving behind the language currently used to describe services, to make sure care givers and users had a shared understanding of the purpose of intermediate care.
- The group developed a series of building blocks and described how these would deliver a core offer to all users, and the extra support some users would need in addition to this. To define the workforce needed, the group focussed on skills and competencies, recognising the need to move away from traditional roles and to a more holistic approach to care delivery.

Executive Summary (3/3)

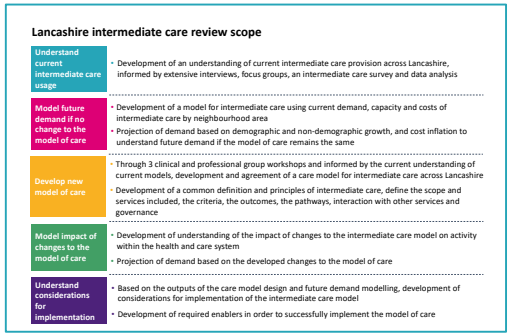
- We audited current usage of beds and undertook analysis to assess the opportunity to shift care into new settings and the potential impact of the new care model, using this to guide the scale of new service that would be required.
- The greatest opportunity is to shift care from the acute setting to intermediate care, increasing intermediate care requirements by 36% over and above the increase required to meet growth in the current system. This would support a 23% reduction in demand for acute bed days and a 45% reduction in the use of short-term care beds.
- Managing growth under the existing model of care would increase cost in intermediate care by £27.5m (66%) in ten years time. The additional cost of treating patients in acute care who could be managed in intermediate care would be a further £51m (14%), and in short-term care beds a further £6.3m (55%) making a **total cost to manage growth of £84.8m.**
- Implementing the new care model, assuming a four year phase in, would generate significant savings for the system against the predicted cost of managing growth under the current model. The greatest impact is seen in acute care, where there would be a 10% reduction in cost in ten years, saving £37.9m, and a £33.8m (78%) increase in cost in intermediate care. This represents a total increase in cost of £28.1m in 10 years, **saving £87.3m of predicted additional cost.**
- The shift represents a 23% increase in IC beds and a 123% increase in staff delivering care in home-based intermediate care services compared to today, against an increase in demographic demand of 26%.
- Finally we identified other considerations to take into account when planning the new services the level at which a service operates (neighbourhood, ICP, ICS, System) needs to balance serving a sufficient population to create a viable service, maintaining specialist expertise where needed and supporting coordination with both neighbourhood services and larger scale providers. Key enablers of delivering the future service include payment and commissioning, information and IT, workforce and estates, alongside clear governance and performance measurement, developing a culture of trust and system behaviours.

The review took the following approach

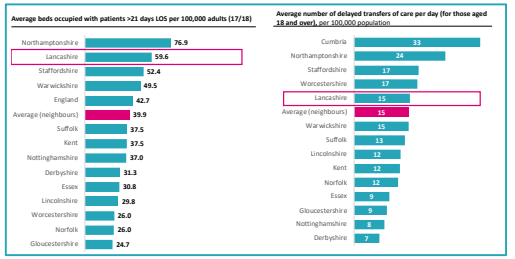


- The intermediate care system in Lancashire and South Cumbria has been a cause for concern for system leaders for some time. There have been both quality and performance issues in parts of the system, and a lack of clarity around what integrated care is seeking to deliver. In recognition of this, CF were commissioned by the Lancashire Better Care Fund Steering Group to:
  - Understand the current usage of intermediate care across Lancashire and South Cumbria
  - Model future demand if there are no changes to the model of intermediate care
  - Develop a new model of care working with local clinicians and professionals
  - Model the impact of changes to the model of intermediate care
  - Understand considerations for implementation

- The Lancashire and South Cumbria health and care system today is characterised by higher than average levels of 'superstranded' patients in acute hospital beds (those staying more than 21 days), and a higher rate of delayed transfers of care.



See slide 6: Overview of aims of the review



See slide 7: Benchmarking Lancashire health and social care activity.

Intermediate care review in Lancashire and South Cumbria

The intermediate care system in Lancashire and South Cumbria has been a cause for concern for system leaders for some time. There have been both quality and performance issues in parts of the system, and a lack of clarity around what integrated care is seeking to deliver. In recognition of this, CF were commissioned by the Lancashire Better Care Fund Steering Group

Why the intermediate care review was commissioned

- An intermediate care service that has been **built up over a number of years** with a number of **different specifications**
- Examples of **unsafe discharges** which led to a severe incident in one of the residential rehab homes
- An **ageing** population with more **complex** needs
- Challenge with **DTOC** and increased number of people waiting in hospital
- High levels of **super-stranded patients** in acute hospitals
- A drive to care for people **closer to home** and maximise independence
- Increased **financial pressures** ensuring value for money is required

Participating organisations in the review

Lancashire County Council
Blackpool Council — Building a better community for all
Blackburn with Darwen Borough Council
Cumbria County Council
NHS Fylde and Wyre Clinical Commissioning Group
NHS West Lancashire Clinical Commissioning Group
NHS Greater Preston Clinical Commissioning Group
NHS Chorley and South Ribble Clinical Commissioning Group
NHS East Lancashire Clinical Commissioning Group
NHS Morecambe Bay Clinical Commissioning Group
NHS Blackpool Clinical Commissioning Group
NHS Blackburn with Darwen Clinical Commissioning Group
Lancashire Teaching Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Trust
Blackpool Teaching Hospitals NHS Foundation Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
NHS Southport and Ormskirk Hospital NHS Trust
NHS Lancashire Care NHS Foundation Trust
virgincare
NHS Midlands and Lancashire Commissioning Support Unit

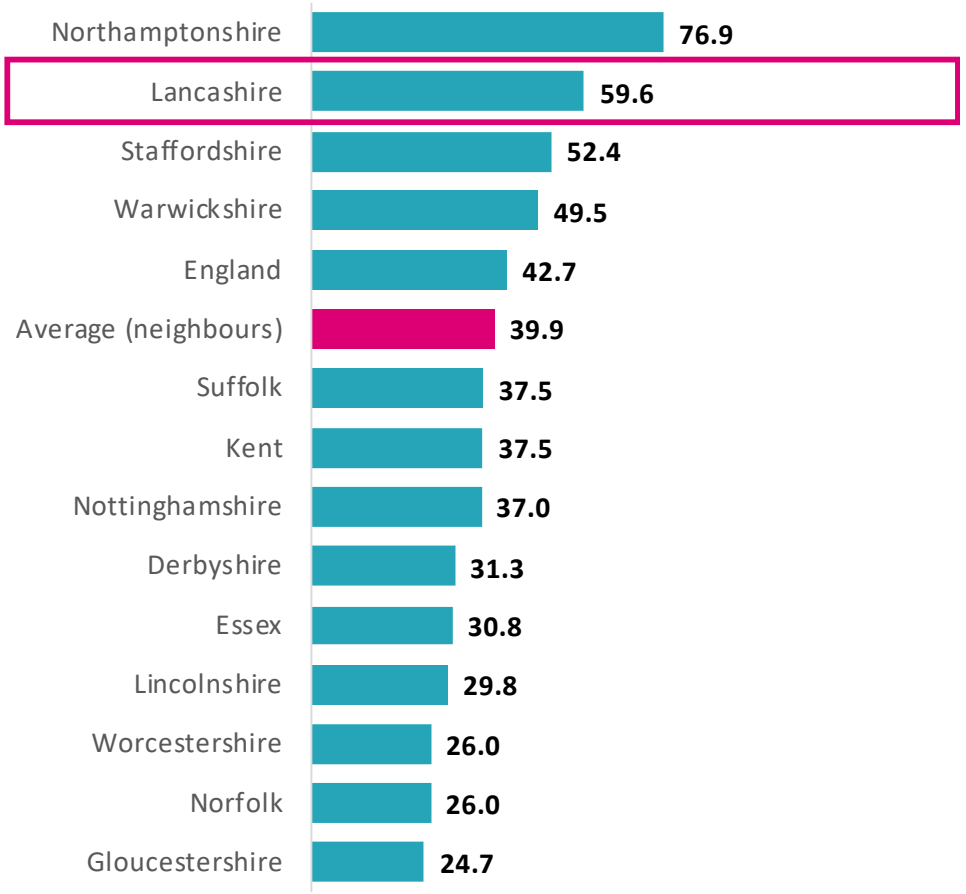
Lancashire intermediate care review scope

Understand current intermediate care usage	• Development of an understanding of current intermediate care provision across Lancashire, informed by extensive interviews, focus groups, an intermediate care survey and data analysis
Model future demand if no change to the model of care	• Development of a model for intermediate care using current demand, capacity and costs of intermediate care by neighbourhood area • Projection of demand based on demographic and non-demographic growth, and cost inflation to understand future demand if the model of care remains the same
Develop new model of care	• Through 3 clinical and professional group workshops and informed by the current understanding of current models, development and agreement of a care model for intermediate care across Lancashire • Development of a common definition and principles of intermediate care, define the scope and services included, the criteria, the outcomes, the pathways, interaction with other services and governance
Model impact of changes to the model of care	• Development of understanding of the impact of changes to the intermediate care model on activity within the health and care system • Projection of demand based on the developed changes to the model of care
Understand considerations for implementation	• Based on the outputs of the care model design and future demand modelling, development of considerations for implementation of the intermediate care model • Development of required enablers in order to successfully implement the model of care

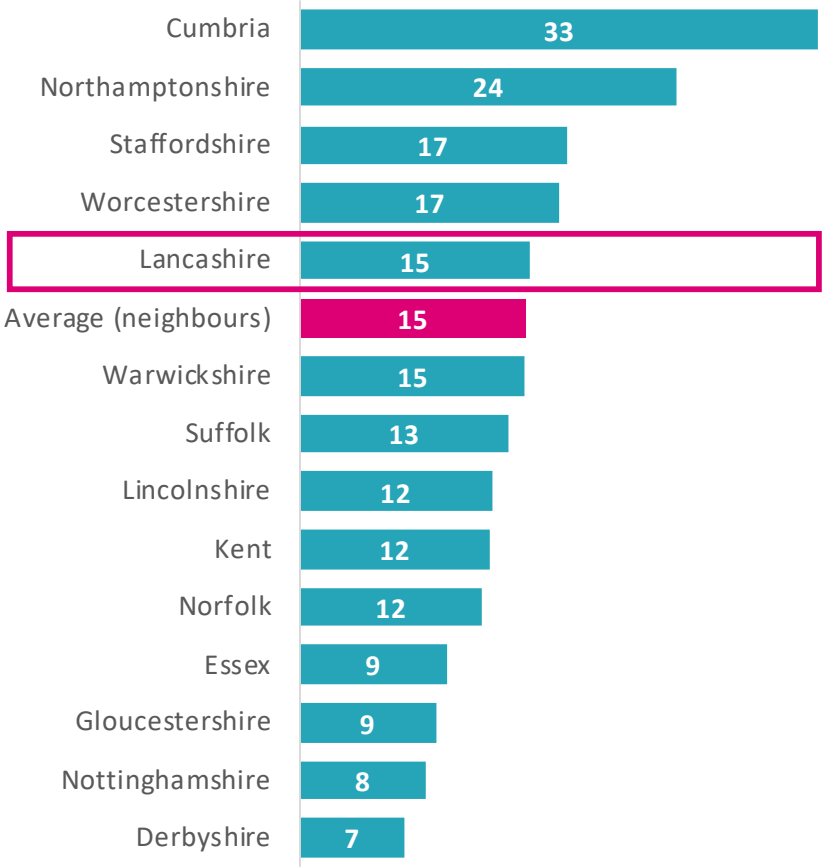
People in Lancashire are spending more time than necessary in a hospital bed

The Lancashire health and care system today is characterised by higher than average levels of 'superstranded' patients in acute hospital beds (those staying more than 21 days), and a higher rate of delayed transfers of care.

Average beds occupied with patients >21 days LOS per 100,000 adults (17/18)

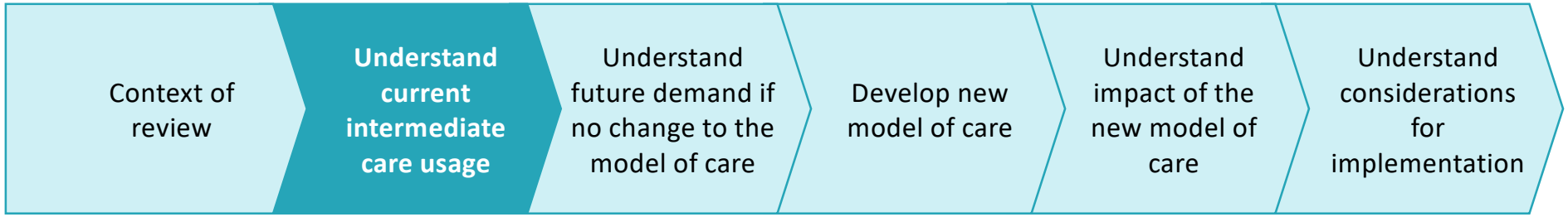


Average number of delayed transfers of care per day (for those aged 18 and over), per 100,000 population



Note: ASCOF calculates yearly average from 12 monthly snapshots taken on a particular day using the Situation Reports
Source: P. Philip (2018) 'Reducing long stays in hospital Annex 1', HED data, Measures from the Adult Social Care Outcomes Framework (ASCOF), NHSE 2013-14 -2017-18, CF analysis

The review took the following approach

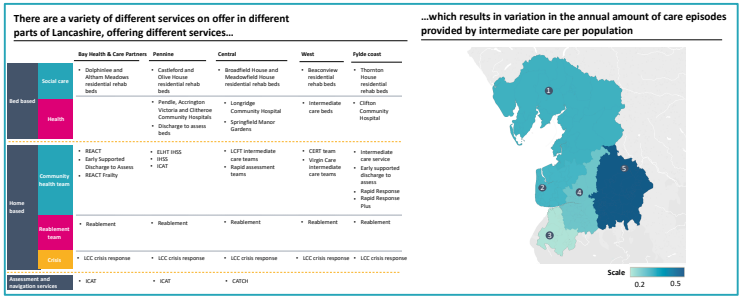


- There is also significant variation in the pattern of use across Lancashire and South Cumbria, reflecting the differences in offer and approach in different areas. Unsurprisingly, given that the focus of care is on additional support to avoid admission to acute care, or to provide rehabilitation and reablement after an an acute episode, the majority of service users are over 75 and frail, with many having dementia or a cognitive impairment.

- There is no consistent model of intermediate care across Lancashire, and the system is complex, fragmented and difficult to navigate for both staff and service users.

- Today, the Lancashire and South Cumbria system spends an estimated £43m/year on around 45,000 episodes of care across a range of bed and home based health and care services.

- There is also significant variation in outcomes, with users in parts of Lancashire and South Cumbria 150% more likely to need admission to a social care bed within 30 days of an intermediate care episode, than in other parts of the system.



See slide 9: Geographical variation in intermediate care provision.

		Number of individual service users	Average days in the service	Hours of contact (home-based services)	Current estimated spend
Bed based	Social	1,815 episodes	29.2 days		£5.1m
	Health	3,520 episodes	28.8 days		£22.5m
Home based	Community	16,105 episodes	12.7 days	3.2 hours	£3.7m
	Reablement	14,229 episodes	22.4 days	29.6 hours	£8.0m
	Crisis and rapid response	9,228 episodes	4.1 days	15.2 hours	£2.0m
Assessment and navigation services					£1.8m
Total intermediate care		44,897 episodes			£43.1m

See slide 12: Current spend and activity on intermediate care.

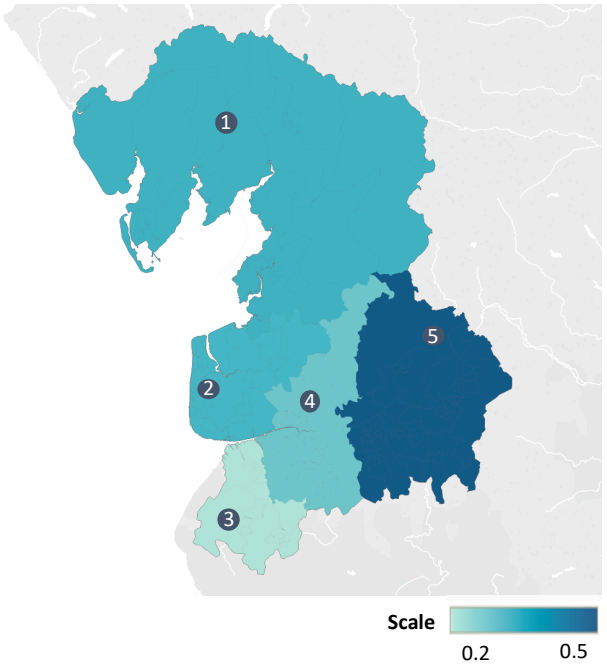
Variation in intermediate care provision across Lancashire

There is also significant variation in the pattern of use across Lancashire and South Cumbria, reflecting the differences in offer and approach in different areas.

There are a variety of different services on offer in different parts of Lancashire, offering different services…

		Bay Health & Care Partners	Pennine	Central	West	Fylde coast
Bed based	Social care	• Dolphinlee and Altham Meadows residential rehab beds	• Castleford and Olive House residential rehab beds	• Broadfield House and Meadowfield House residential rehab beds	• Beaconview residential rehab beds	• Thornton House residential rehab beds
	Health		• Pendle, Accrington Victoria and Clitheroe Community Hospitals • Discharge to assess beds	• Longridge Community Hospital • Springfield Manor Gardens	• Intermediate care beds	• Clifton Community Hospital
Home based	Community health team	• REACT • Early Supported Discharge to Assess • REACT Frailty	• ELHT IHSS • IHSS • ICAT	• LCFT intermediate care teams • Rapid assessment teams	• CERT team • Virgin Care intermediate care teams	• Intermediate care service • Early supported discharge to assess • Rapid Response • Rapid Response Plus
	Reablement team	• Reablement	• Reablement	• Reablement	• Reablement	• Reablement
	Crisis	• LCC crisis response	• LCC crisis response	• LCC crisis response	• LCC crisis response	• LCC crisis response
Assessment and navigation services		• ICAT	• ICAT	• CATCH		

…which results in variation in the annual amount of care episodes provided by intermediate care per population



Interpreting this graphic

In this graphic, the darker the colour, the more intermediate care is provided per population, which has been weighted to take into account demographic differences. The scale is the average number of times the population likely to use intermediate care uses a service in a year.

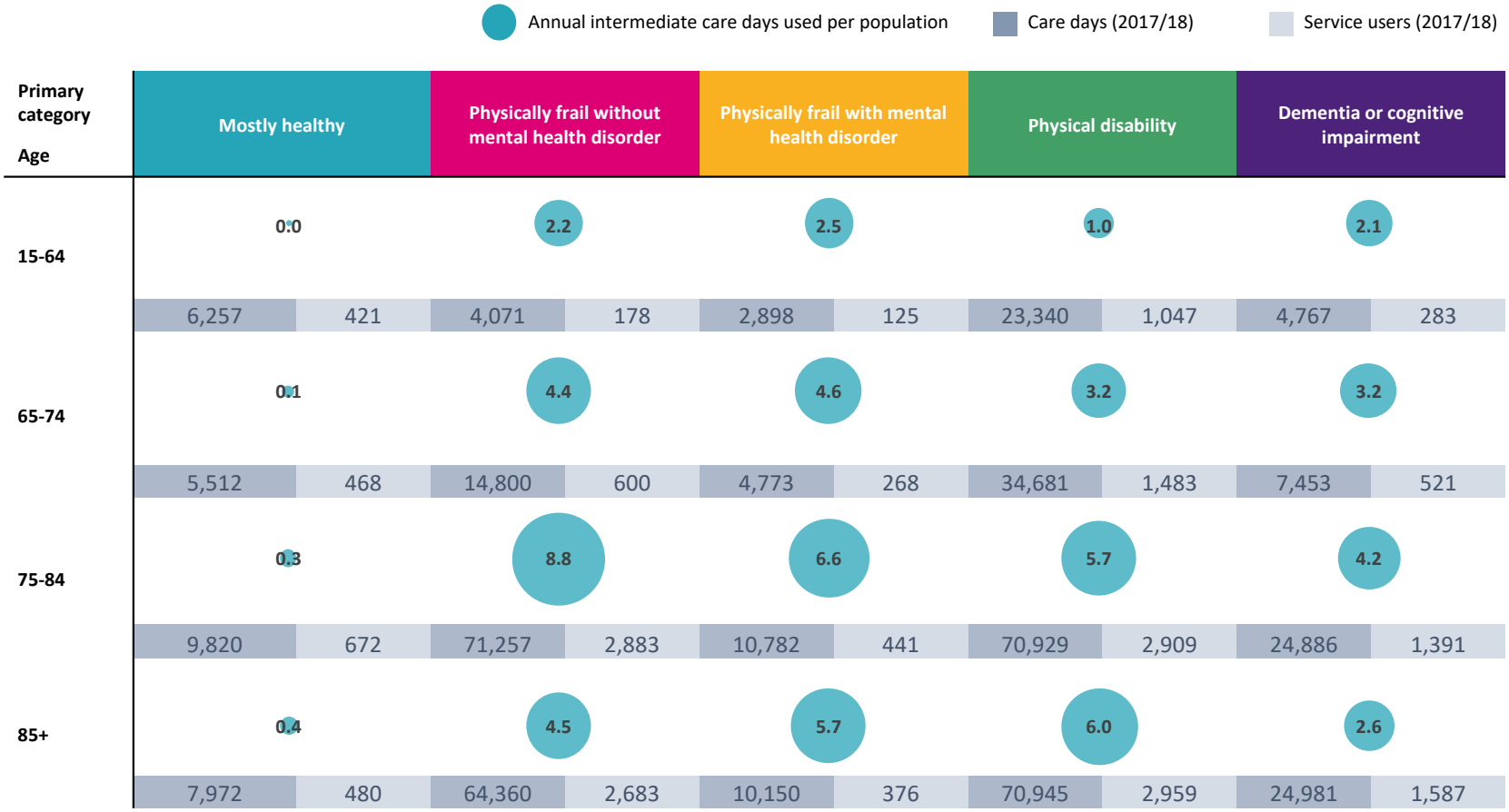
Key

1. Bay Health & Care Partners
2. Fylde Coast
3. West Lancashire
4. Central Lancashire
5. Pennine Lancashire

Source: Lancashire and South Cumbria intermediate care review dataset 2015-2019, CF analysis
Note: population sizes have been weighted for population demographics, likelihood of using intermediate care and deprivation

Use of intermediate care services by groups of the population

Unsurprisingly, given that the focus of care is on additional support to avoid admission to acute care, or to provide rehabilitation and reablement after an an acute episode, the majority of service users are over 75 and frail, with many having dementia or a cognitive impairment.



Source: Lancashire and South Cumbria intermediate care review dataset 2015-2019, CF analysis

How people experience the services

There is no consistent model of intermediate care across Lancashire, and the system is complex, fragmented and difficult to navigate for both staff and service users.

1. Jane is now medically optimised. During her stay in hospital she has become more unsteady on her feet and an acute assessment flags concerns about her ability to manage independently at home, despite Jane wanting to be at home. There is a lack of clarity about the range of services which can support people to be safe and rehabilitate at home, so Jane is referred to a residential rehab facility.

2. Jane only wants to go to a bed that is near her home and so waits for a bed to become available in that location. Her choice of residential rehab site has a number of complex patients and they don't have the capacity to take anyone else. This delays Jane's discharge.

3. A rehab bed becomes available and Jane is discharged from the acute. She waits for several hours for transport, and arrives late in the evening when there are few staff on site to help her settle in.

4. The therapy staff at the residential rehab site don't have all of Jane's notes and aren't sure what treatment she needs. They don't think that she needed to receive bedded rehab.

5. Jane receives therapy 3 times a week. After 2 weeks she has achieved her mobility goals. Jane is told that she is ready to go home. Jane had expected to stay for 6 weeks and receive therapy every day and is reluctant to leave because she has got used to the higher level of care provided in a residential facility.

6. Jane needs a package of care to support her for a short time when she goes home. She waits in residential rehab for 72hrs for a social worker assessment and a further 3 days for her social worker to find a package of care.

If Jane could have gone straight home from hospital receiving support and reablement at home, the decrease in her confidence in her ability to manage independently could have been avoided.

Source: Illustrative typical patient pathway constructed with the Lancashire intermediate care clinical and professional group

Estimated spend on intermediate care

Today, the Lancashire and South Cumbria system spends an estimated £43m/year on around 45,000 episodes of care across a range of bed and home based health and care services.

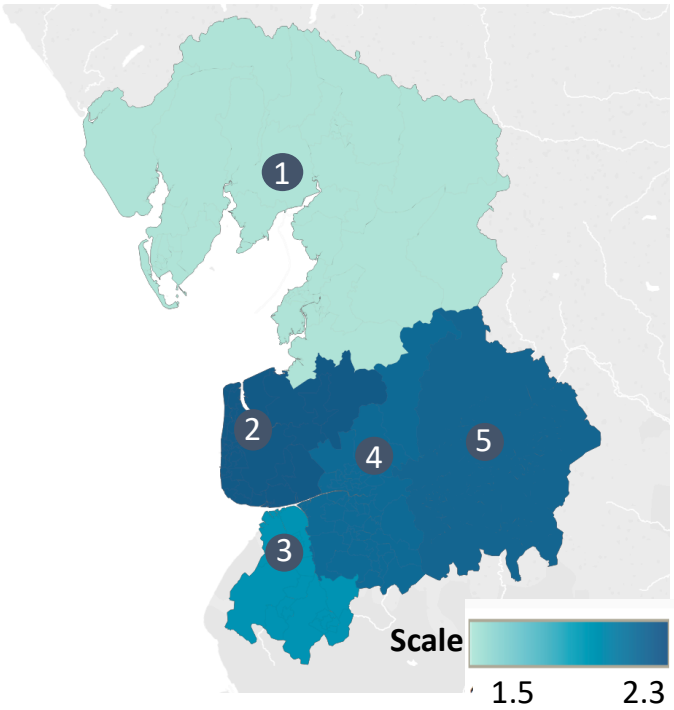
		Number of individual service users	Average days in the service	Hours of contact (home-based services)	Current estimated spend
Bed based	Social	1,815 episodes	29.2 days		£5.1m
	Health	3,520 episodes	28.8 days		£22.5m
Home based	Community	16,105 episodes	12.7 days	3.2 hours	£3.7m
	Reablement	14,229 episodes	22.4 days	29.6 hours	£8.0m
	Crisis and rapid response	9,228 episodes	4.1 days	15.2 hours	£2.0m
Assessment and navigation services					£1.8m
Total intermediate care		44,897 episodes			£43.1m

Source: Lancashire and South Cumbria intermediate care review dataset 2015-2019, CF analysis

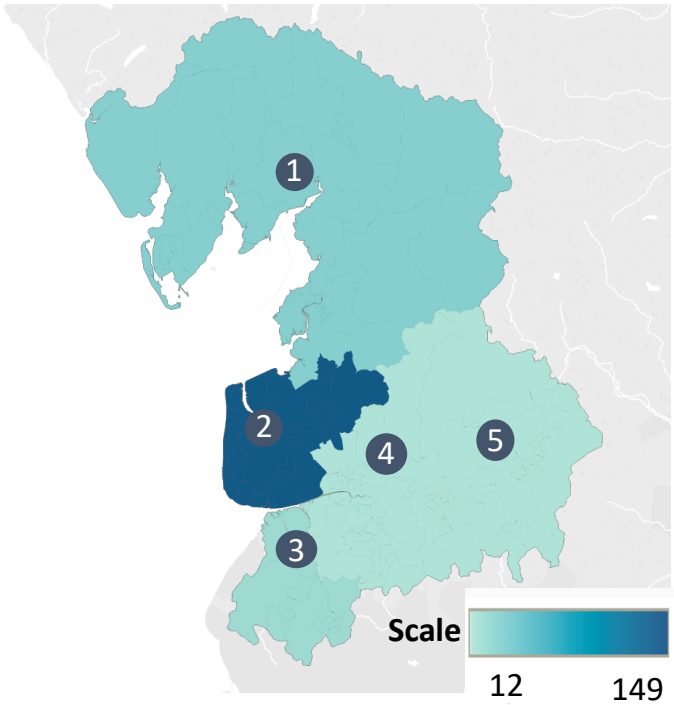
How effective intermediate care is at keeping people at home and independent

There is also significant variation in outcomes, with users in parts of Lancashire and South Cumbria 150% more likely to need admission to a social care bed within 30 days of an intermediate care episode, than in other parts of the system.

Areas show variation in the effectiveness at reducing admission to an acute hospital in the 30 days following using intermediate care…



And in the effectiveness at reducing admission to a nursing or residential bed in the 90 days following using intermediate care



Key

1. North Lancashire
2. Fylde and Wyre
3. West Lancashire
4. Central Lancashire
5. East Lancashire

Interpreting this graphic

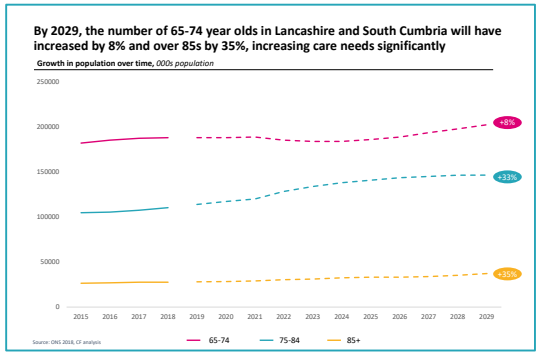
In this graphic, the darker the colour, the more likely it is that someone using an intermediate care service in that area is to spend days in an acute hospital (on the left), or days in a nursing or residential home (on the right) following using an intermediate care service. In both graphics, the scale is the average number of days used.

Source: Lancashire and South Cumbria intermediate care review dataset 2015-2019, CF analysis
Note: populations have been weighted for intermediate care population segments 65+ and deprivation.

The review took the following approach

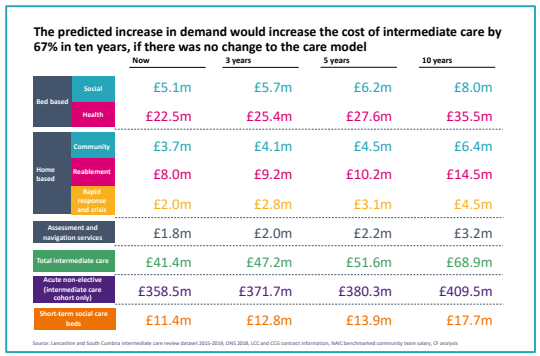
Context of review	Understand current intermediate care usage	**Understand future demand if no change to the model of care**	Develop new model of care	Understand impact of the new model of care	Understand considerations for implementation

- We modelled the potential future demand for intermediate care based on demographic change, assuming there was no change in the care model. By 2029, there will be many more elderly people in Lancashire and South Cumbria - 8% more aged between 65 and 74, 33% more aged between 75 and 84 and 35% more over 85.



See slide 15: Projected ONS demographic growth.

- While demographic changes would increase the demand for care episodes by 26% in Lancashire and South Cumbria, cost inflation and the increased shift towards more costly episodes of bed based care would increase the overall cost by 67%, delivering this would cost an additional £27.5m in ten years time, assuming no change to the model of care. Additional demand in the acute and social care sectors that could be managed by intermediate care adds a further £51m and £6.3m, respectively, to system cost.



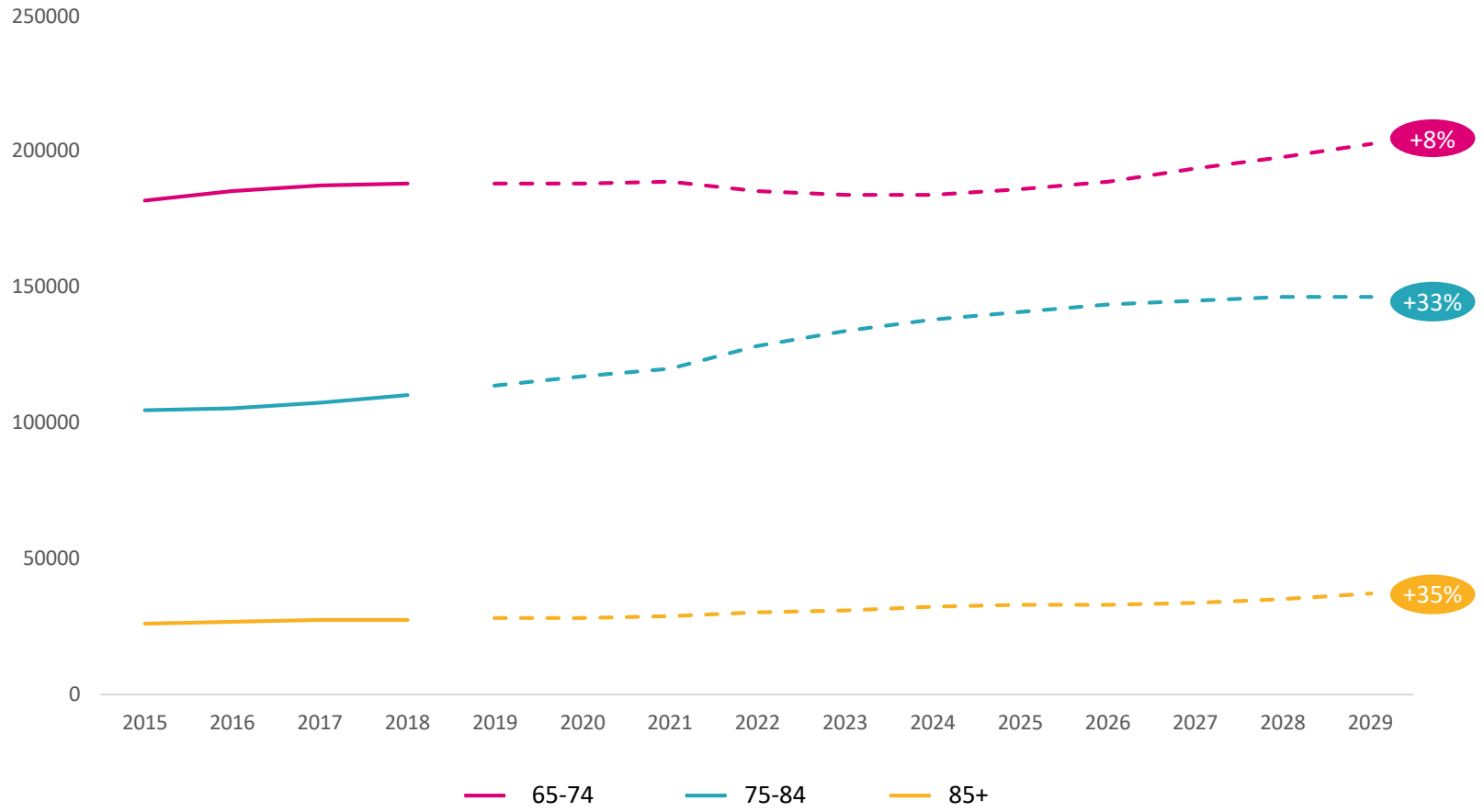
		Now	3 years	5 years	10 years
Bed based	Social	£5.1m	£5.7m	£6.2m	£8.0m
	Health	£22.5m	£25.4m	£27.6m	£35.5m
Home based	Community	£3.7m	£4.1m	£4.5m	£6.4m
	Reablement	£8.0m	£9.2m	£10.2m	£14.5m
	Rapid response and crisis	£2.0m	£2.8m	£3.1m	£4.5m
Assessment and navigation services		£1.8m	£2.0m	£2.2m	£3.2m
Total intermediate care		£41.4m	£47.2m	£51.6m	£68.9m
Acute non-elective (intermediate care cohort only)		£358.5m	£371.7m	£380.3m	£409.5m
Short-term social care beds		£11.4m	£12.8m	£13.9m	£17.7m

See slide 16: Overview of projected cost of intermediate care, acute care and short-term social care beds over the next 10 years.

Population growth

We modelled the potential future demand for intermediate care based on demographic change, assuming there was no change in the care model. By 2029, there will be many more elderly people in Lancashire and South Cumbria - 8% more aged between 65 and 74, 33% more aged between 75 and 84 and 35% more over 85.

Growth in population over time, *000s population*



Source: ONS 2018, CF analysis

Predicted change in costs

While demographic changes would increase the demand for care episodes by 26% in Lancashire and South Cumbria, cost inflation and the increased shift towards more costly episodes of bed based care would increase the overall cost by 67%, delivering this would cost an additional £27.5m in ten years time, assuming no change to the model of care. Additional demand in the acute and social care sectors that could be managed by intermediate care adds a further £51m and £6.3m, respectively, to system cost.

		Now	3 years	5 years	10 years
Bed based	Social	1,815 episodes	1,943 episodes	2,035 episodes	2,342 episodes
	Health	3,520 episodes	3,752 episodes	3,917 episodes	4,468 episodes
Home based	Community	16,105 episodes	17,052 episodes	17,726 episodes	19,974 episodes
	Reablement	14,229 episodes	15,135 episodes	15,782 episodes	17,943 episodes
	Crisis and rapid response	9,228 episodes	9,834 episodes	10,266 episodes	11,708 episodes
Total intermediate care		44,897 episodes	47,717 episodes	49,726 episodes	56,435 episodes
Acute non-elective (intermediate care cohort only)		123,597 episodes	119,941 episodes	117,668 episodes	111,578 episodes
Short-term social care beds		3,276 episodes	3,484 episodes	3,632 episodes	4,128 episodes

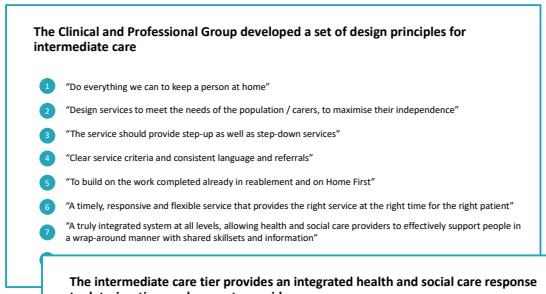
Source: Lancashire and South Cumbria intermediate care review data – 2015-2019, ONS 2018, CF analysis

The review took the following approach

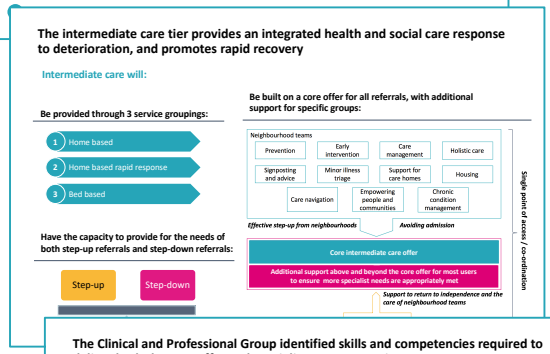
- We facilitated a clinical and professional group to develop a new care model through a series of workshops. The group reviewed their current models and best practice examples from elsewhere, and agreed a set of design principles. These were focussed on keeping care at home, maximising independence and providing timely integrated health and care with smooth transitions between care settings to support both step up and step down.

- The group recognised that delivering against these design principles required breaking down the traditional barriers between services and developed a model of care based on only three services. This would require leaving behind the language currently used to describe services, to make sure care givers and users had a shared understanding of the purpose of intermediate care.

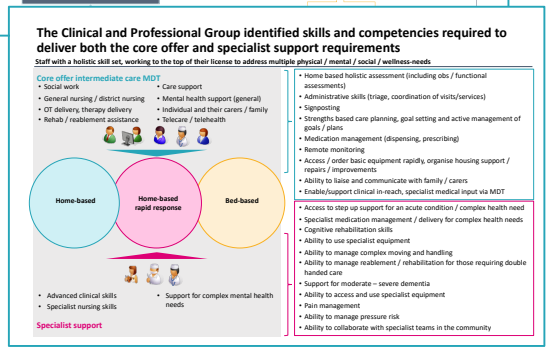
- The group developed a series of building blocks and described how these would deliver a core offer to all users, and the extra support some users would need in addition to this. To define the workforce needed, the group focussed on skills and competencies, recognising the need to move away from traditional roles and to a more holistic approach to care delivery.



See slide 18: Design principles developed for intermediate care.



See slide 19: Designed intermediate care model with three services, capacity for step up and down, and interactions with the rest of the system.



See slide 20: Definition of a multi-disciplinary workforce based on skills and competencies.

Design principles

We facilitated a clinical and professional group to develop a new care model through a series of workshops. The group reviewed their current models and best practice examples from elsewhere, and agreed a set of design principles. These were focussed on keeping care at home, maximising independence and providing timely integrated health and care with smooth transitions between care settings to support both step up and step down.

1. "Do everything we can to keep a person at home"
2. "Design services to meet the needs of the population / carers, to maximise their independence"
3. "The service should provide step-up as well as step-down services"
4. "Clear service criteria and consistent language and referrals"
5. "To build on the work completed already in reablement and on Home First"
6. "A timely, responsive and flexible service that provides the right service at the right time for the right patient"
7. "A truly integrated system at all levels, allowing health and social care providers to effectively support people in a wrap-around manner with shared skillsets and information"
8. "Maintain flow in intermediate care through trusted referrals and smooth transitions between care settings"

Source: Lancashire and South Cumbria intermediate care clinical and professional group workshops

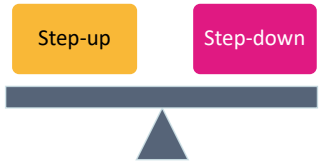
Overall model and how it is described

The group recognised that delivering against these design principles required breaking down the traditional barriers between services and developed a model of care based on only three services. This would require leaving behind the language currently used to describe services, to make sure care givers and users had a shared understanding of the purpose of intermediate care.

The intermediate care tier provides an integrated health and social care response to deterioration, and promotes rapid recovery

Intermediate care will:

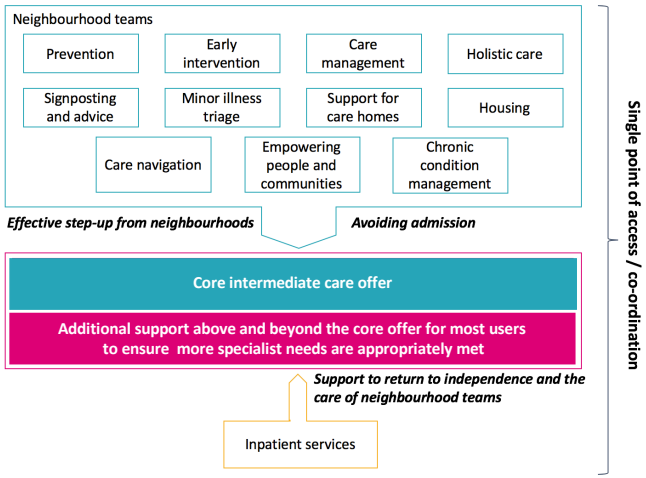
Have the capacity to provide for the needs of both step-up referrals and step-down referrals:



Be provided through 3 service groupings:

1. Home based
2. Home based rapid response
3. Bed based

Be built on a core offer for all referrals, with additional support for specific groups:



How we should be describing intermediate care

- "Support for a short period of time to safely stay at home or return home, that best fits your assessed needs"
- "Help to get you back on your feet when you've been unwell or are finding things more difficult, either at home or away from home temporarily in a bedded unit"
- "Get better, get stronger"
- "You may have therapy or you may not need it"
- "Time limited care based on your needs"
- "Intermediate care might last for a couple of days, or for a longer period of time as your ongoing assessment determines"
- "Ongoing assessment helps to make a longer-term plan"

Source: Lancashire and South Cumbria intermediate care clinical and professional group workshops

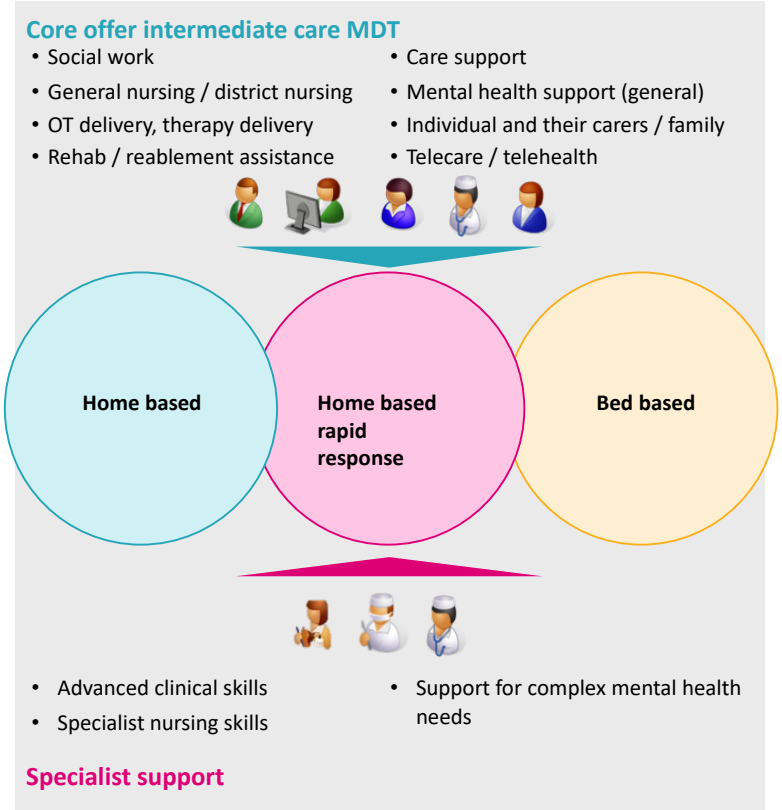
Service building blocks and skills required to best support individuals

The group developed a series of building blocks and described how these would deliver a core offer to all users, and the extra support some users would need in addition to this. To define the workforce needed, the group focussed on skills and competencies, recognising the need to move away from traditional roles and to a more holistic approach to care delivery.

Six building blocks to support an intermediate care service as described by the group…

1. Health and social care professionals working together
2. NHS and social care support
3. Local health and social care point of contact
4. Trusted assessor model
5. Shared care records
6. Appropriate estates, equipment , IT, staffing and training

…supported by staff with a holistic skill set, working to the top of their license to address multiple physical / mental / social / wellness-needs in conjunction with families and technology



Source: Lancashire and South Cumbria intermediate care clinical and professional group workshops

Impact for individuals in avoiding acute hospital admission

The group described the impact of changing the way the intermediate care service works in this way for individuals who use the services, and what the outcomes for those people would have been through better supporting them at home.

A core offer pathway for step-up to intermediate care was developed…

1. Jane is 70. She lives at home independently with homecare support from a LCC carer who comes in once a day. She does not have a diagnosis of dementia or a cognitive impairment.
2. One day, Jane's carer finds Jane feverish and very confused. She suspects Jane is suffering from a UTI. Jane is not safe to be left alone.
3. Jane's carer has received training on accessing the single point of access for her geography and is aware of the types of service available (due to SPA engagement with care providers and the public). Jane's carer calls the SPA and refers Jane.
4. The SPA identifies and sends the appropriate resource with the right skills to look after Jane. A nurse prescriber from the community rapid response service arrives within 2 hours who prescribes Jane with a course of antibiotics. The pharmacy deliver the prescription within 2 hours. The rapid response service provides appropriate care and support for Jane for 72 hrs.
5. Within 72hrs, Jane is feeling better but is a bit unsteady on her feet. The rapid response team holistically assess Jane in her home to establish her ongoing needs. They make a referral through the SPA to the Reablement service and explain to Jane that she can expect up to 37 hours of support.
6. Reablement returns Jane to her baseline. The SPA also liaises with Jane, her carer and her neighbourhood care teams to create a plan to catch symptoms of another UTI early and prevent the need to access intermediate care.

Jane is looked after in her own home as she recovers from the UTI. She receives reablement at home and returns to her baseline level of mobility and independence.

Source: Lancashire and South Cumbria intermediate care clinical and professional group workshops

Impact for individuals to facilitate smooth discharge from acute hospitals

The group described the impact of changing the way the intermediate care service works in this way for individuals who use the services, and what the outcomes for those people would have been through better supporting them at home.

...as well as the core offer pathway for step down

1. Jane is in hospital. She is almost medically optimised to leave but during her stay she has become more unsteady on her feet. Jane really wants to go home but she is worried about how she will manage independently, as she did prior to her admission.
2. Intermediate care services and criteria in the community are well known. Ward staff tell Jane about potential services that could support her at home and what she might expect. Jane consents to receive intermediate care at home.
3. Ward staff know the benefit of assessing Jane in her own home to establish clear support needs and goals. They contact the intermediate care SPA to discharge Jane on the Home First pathway.
4. Jane is discharged from the acute. There is sufficient capacity in the ambulance service and Jane returns home in a timely fashion. She goes home with support from the rapid response service to assess her needs at home.
5. The rapid response team holistically assess Jane at home at the appropriate time. They think Jane requires reablement at home to maximise her confidence and independence. Their trusted needs assessment is sent to the SPA.
6. The Reablement service work together with Jane to decide her goals. Jane receives 25 hours of Reablement support, achieving her goals and returning to her baseline level of function. The Reablement service assess Jane. She does not need a long-term package of care, but they do set up telecare for her.
7. Assessment at home meant it was clear what Jane's capabilities and challenges were when living in her home environment, so she received clear goals tailored to her needs.

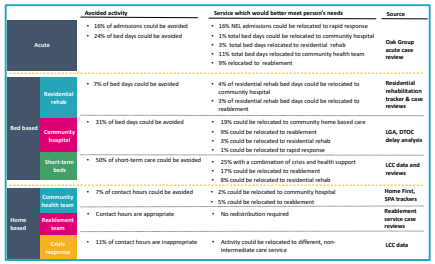
Jane knows she would receive up to 37 hours of support in whatever configuration (dependent on her progress) at home to help maximise her independence and is willing to participate.

Source: Lancashire and South Cumbria intermediate care clinical and professional group workshops

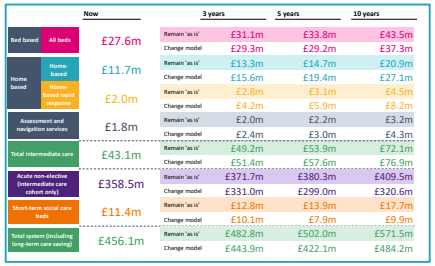
The review took the following approach

Context of review	Understand current intermediate care usage	Understand future demand if no change to the model of care	Develop new model of care	**Understand impact of the new model of care**	Understand considerations for implementation

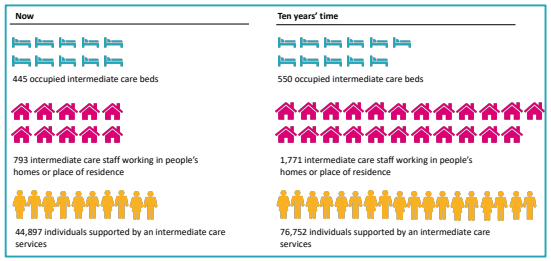
- We audited current usage of beds and undertook analysis to assess the opportunity to shift care into new settings and the potential impact of the new care model, using this to guide the scale of new service that would be required.
- The greatest opportunity is to shift care from the acute setting to intermediate care, increasing intermediate care requirements by 36% over and above the increase required to meet growth in the current system. This would support a 23% reduction in demand for acute bed days and a 45% reduction in the use of short-term care beds.
- Managing growth under the existing model of care would increase cost in intermediate care by £27.5m (66%) in ten years time. The additional cost of treating patients in acute care who could be managed in intermediate care would be a further £51m (14%), and in short-term care beds a further £6.3m (55%) making a **total cost to manage growth of £84.8m.**
- Implementing the new care model, assuming a four year phase in, would generate significant savings for the system against the predicted cost of managing growth under the current model. The greatest impact is seen in acute care, where there would be a 10% reduction in cost in ten years, saving £37.9m, and a £33.8m (78%) increase in cost in intermediate care. This represents a total increase in cost of £28.1m in 10 years, **saving £87.3m of predicted additional cost.**
- The shift represents a 23% increase in IC beds and a 123% increase in staff delivering care in home-based intermediate care services compared to today, against an increase in demographic demand of 26%.



See slide 24: Opportunities to shift care between settings.



See slide 25: Projected costs of intermediate care through implementing the new model of care.



See slide 26: Impact of the new model of care on beds and staff.

Shifting care to more appropriate services and settings

We audited current usage of beds and undertook analysis to assess the opportunity to shift care into new settings and the potential impact of the new care model, using this to guide the scale of new service that would be required. The greatest opportunity is to shift care from the acute setting to intermediate care, increasing intermediate care requirements by 36% over and above the increase required to meet growth in the current system. This would support a 23% reduction in demand for acute bed days and a 45% reduction in the use of short-term care beds.

		Avoided activity	Service which would better meet person's needs	Source
Acute		• 16% of admissions could be avoided • 24% of bed days could be avoided	• 16% NEL admissions could be relocated to rapid response • 1% total bed days could be relocated to community hospital • 3% total bed days relocated to residential rehab • 11% total bed days relocated to community health team • 9% relocated to reablement	Oak Group acute case review
Bed based	Residential rehab	• 7% of bed days could be avoided	• 4% of residential rehab bed days could be relocated to community hospital • 3% of residential rehab bed days could be relocated to reablement	Residential rehabilitation tracker & case reviews
	Community hospital	• 31% of bed days could be avoided	• 19% could be relocated to community home based care • 9% could be relocated to reablement • 3% could be relocated to residential rehab • 1% could be relocated to rapid response	LGA, DTOC delay analysis
	Short-term beds	• 50% of short-term care could be avoided	• 25% with a combination of crisis and health support • 17% could be relocated to reablement • 8% could be relocated to residential rehab	LCC data and reviews
Home based	Community health team	• 7% of contact hours could be avoided	• 2% could be relocated to community hospital • 5% could be relocated to reablement	Home First, SPA trackers
	Reablement team	• Contact hours are appropriate	• No redistribution required	Reablement service case reviews
	Crisis response	• 11% of contact hours are inappropriate	• Activity could be relocated to different, non-intermediate care service	LCC data

Source: Lancashire and South Cumbria intermediate care review dataset 2015-2019, CF analysis

Impact on managing growth in services and costs

Managing growth under the existing model of care would increase cost in intermediate care by £27.5m (66%) in ten years time. The additional cost of treating patients in acute care who could be managed in intermediate care would be a further £51m (14%), and in short-term care beds a further £6.3m (55%) making a **total cost to manage growth of £84.8m.** Implementing the new care model, assuming a four year phase in, would generate significant savings for the system against the predicted cost of managing growth under the current model. The greatest impact is seen in acute care, where there would be a 10% reduction in cost in ten years, saving £37.9m, and a £33.8m (78%) increase in cost in intermediate care. This represents a total increase in cost of £28.1m in 10 years, **saving £87.3m of predicted additional cost.**

		Now		3 years	5 years	10 years
Bed based	All beds	£27.6m	Remain 'as is'	£31.1m	£33.8m	£43.5m
			Change model	£29.3m	£29.2m	£37.3m
Home based	Home-based	£11.7m	Remain 'as is'	£13.3m	£14.7m	£20.9m
			Change model	£15.6m	£19.4m	£27.1m
	Home-based rapid response	£2.0m	Remain 'as is'	£2.8m	£3.1m	£4.5m
			Change model	£4.2m	£5.9m	£8.2m
Assessment and navigation services		£1.8m	Remain 'as is'	£2.0m	£2.2m	£3.2m
			Change model	£2.4m	£3.0m	£4.3m
Total intermediate care		£43.1m	Remain 'as is'	£49.2m	£53.9m	£72.1m
			Change model	£51.4m	£57.6m	£76.9m
Acute non-elective (intermediate care cohort only)		£358.5m	Remain 'as is'	£371.7m	£380.3m	£409.5m
			Change model	£331.0m	£299.0m	£320.6m
Short-term social care beds		£11.4m	Remain 'as is'	£12.8m	£13.9m	£17.7m
			Change model	£10.1m	£7.9m	£9.9m
Total system (including long-term care saving)		£456.1m	Remain 'as is'	£482.8m	£502.0m	£571.5m
			Change model	£443.9m	£422.1m	£484.2m

Source: Lancashire and South Cumbria intermediate care review data – 2015-2019, ONS 2018, CF analysis

Modelled future use of intermediate care through changing the service: Impact on the number of beds and staff and outcomes for individuals

The shift represents a 23% increase in IC beds and a 123% increase in staff delivering care in home-based intermediate care services compared to today, against an increase in demographic demand of 26%.

Now

445 occupied intermediate care beds

793 intermediate care staff working in people's homes or place of residence

44,897 individuals supported by an intermediate care services

Ten years' time with current model of care

571 occupied intermediate care beds

1,106 intermediate care staff working in people's homes or place of residence

56,435 individuals supported by an intermediate care services

Ten years' time with new model of care

550 occupied intermediate care beds

1,771 intermediate care staff working in people's homes or place of residence

76,752 individuals supported by an intermediate care services

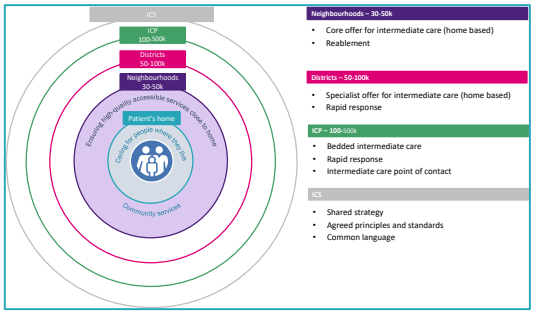
Source: Lancashire and South Cumbria intermediate care review data – 2015-2019, ONS 2018, CF analysis

The review took the following approach

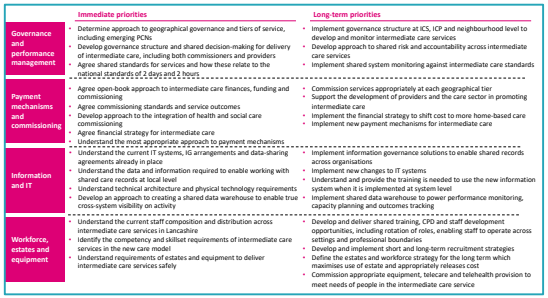
Context of review → Understand current intermediate care usage → Understand future demand if no change to the model of care → Develop new model of care → Understand impact of the new model of care → **Understand considerations for implementation**

- Finally we identified other considerations to take into account when planning the new services the level at which a service operates (neighbourhood, ICP, ICS, System) needs to balance serving a sufficient population to create a viable service, maintaining specialist expertise where needed and supporting coordination with both neighbourhood services and larger scale providers.

- Key enablers of delivering the future service include payment and commissioning, information and IT, workforce and estates, alongside clear governance and performance measurement, developing a culture of trust and system behaviours.



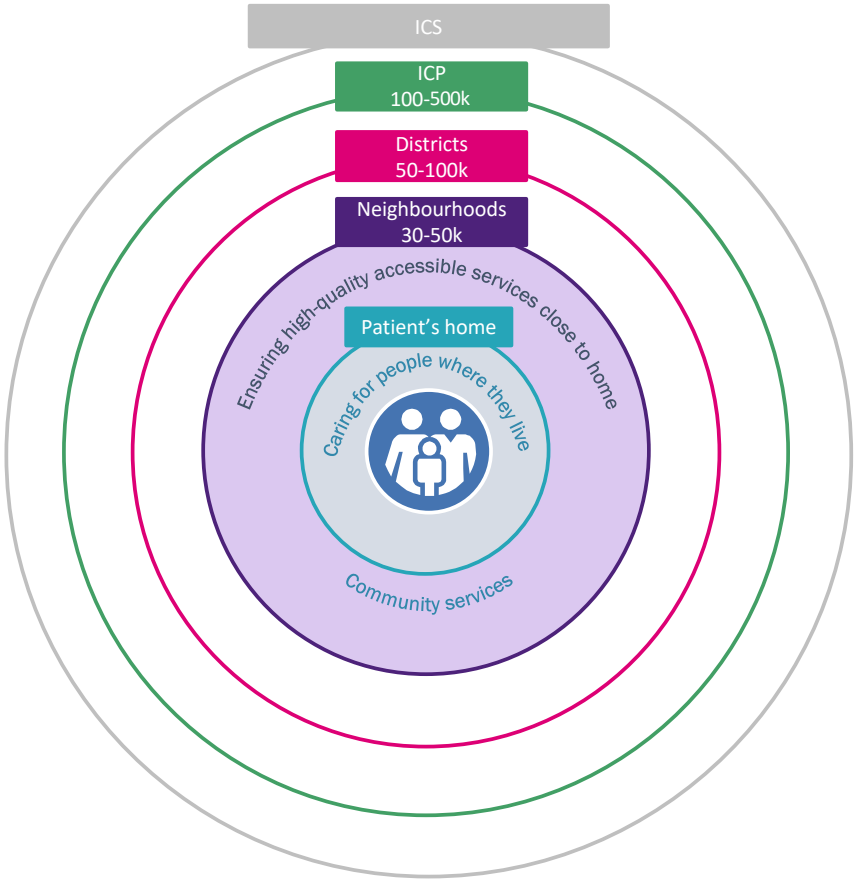
See slide 28: Identifying scales at which intermediate care should be delivered.



See slide 29: Key enablers for implementing the new intermediate care model.

Geographical organisation of services

Finally we identified other considerations to take into account when planning the new services the level at which a service operates (neighbourhood, ICP, ICS, System) needs to balance serving a sufficient population to create a viable service, maintaining specialist expertise where needed and supporting coordination with both neighbourhood services and larger scale providers.



Neighbourhoods – 30-50k

- Core offer for intermediate care (home based)
- Reablement

Districts – 50-100k

- Specialist offer for intermediate care (home based)
- Rapid response

ICP – 100-500k

- Bedded intermediate care
- Rapid response
- Intermediate care point of contact

ICS

- Shared strategy
- Agreed principles and standards
- Common language

Source: Lancashire and South Cumbria intermediate care review

Key enablers to work on as next steps towards delivering the changes outlined

Key enablers of delivering the future service include payment and commissioning, information and IT, workforce and estates, alongside clear governance and performance measurement, developing a culture of trust and system behaviours.

	Immediate priorities	Long-term priorities
Governance and performance management	• Determine approach to geographical governance and tiers of service, including emerging PCNs • Develop governance structure and shared decision-making for delivery of intermediate care, including both commissioners and providers • Agree shared standards for services and how these relate to the national standards of 2 days and 2 hours	• Implement governance structure at ICS, ICP and neighbourhood level to develop and monitor intermediate care services • Develop approach to shared risk and accountability across intermediate care services • Implement shared system monitoring against intermediate care standards
Payment mechanisms and commissioning	• Agree open-book approach to intermediate care finances, funding and commissioning • Agree commissioning standards and service outcomes • Develop approach to the integration of health and social care commissioning • Agree financial strategy for intermediate care • Understand the most appropriate approach to payment mechanisms	• Commission services appropriately at each geographical tier • Support the development of providers and the care sector in promoting intermediate care • Implement the financial strategy to shift cost to more home-based care • Implement new payment mechanisms for intermediate care
Information and IT	• Understand the current IT systems, IG arrangements and data-sharing agreements already in place • Understand the data and information required to enable working with shared care records at local level • Understand technical architecture and physical technology requirements • Develop an approach to creating a shared data warehouse to enable true cross-system visibility on activity	• Implement information governance solutions to enable shared records across organisations • Implement new changes to IT systems • Understand and provide the training is needed to use the new information system when it is implemented at system level • Implement shared data warehouse to power performance monitoring, capacity planning and outcomes tracking
Workforce, estates and equipment	• Understand the current staff composition and distribution across intermediate care services in Lancashire • Identify the competency and skillset requirements of intermediate care services in the new care model • Understand requirements of estates and equipment to deliver intermediate care services safely	• Develop and deliver shared training, CPD and staff development opportunities, including rotation of roles, enabling staff to operate across settings and professional boundaries • Develop and implement short and long-term recruitment strategies • Define the estates and workforce strategy for the long term which maximises use of estate and appropriately releases cost • Commission appropriate equipment, telecare and telehealth provision to meet needs of people in the intermediate care service

Source: Lancashire and South Cumbria intermediate care review